**DISSOLVEMENT/TERMINATION OF COLLABORATIVE AGREEMENT**

NAME:_____

RXA NUMBER_____

COLLABORATIVE AGREEMENT DISSOLVED EFFECTIVE:_____

DATE

Name of Collaborative Physician: _____

Business Address: _____

_____

Zip _____

Business Phone:_____

West Virginia Medical License number:_____

Reason for dissolvement of collaborative agreement:_____

_____

Prescriber's Signature _____ Date_____

SUBSCRIBED AND SWORN TO BEFORE ME this _____day of

_____20___

My commission expires_____

_____

(SEAL) Signature of Notary Public

Revised 12-2014